

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8357

CERTIFICATE OF DEATH

Reg. Dist. No. 103-

08333

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| c. LENGTH OF STAY IN 1b <u>2 1/2 DAYS</u> | | d. STREET ADDRESS <u>2439 E. North Ave.,</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>PETER</u> Last <u>Antone</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1956</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar. 22, 1880</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>GEORGE H. Antone</u> | | 14. MOTHER'S MARDEN NAME <u>HEIN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Mrs. Sofi Antone, 2439 E. North Ave., Balto., Md.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive and arteriosclerotic Cardio</u> DUE TO <u>Vascular Disease</u> (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>Aug. 10th, 1956</u> to <u>Aug. 12th, 1956</u> , that I last saw the deceased alive on <u>7:30 P.M. Aug. 12th, 1956</u> , and that death occurred at <u>1:25 P.M. 8/13/56</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D. | | ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Haure de Grace, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u> | | DATE SIGNED <u>8/13/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug. 16, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McGee & Son</u> | | 24a. REC'D BY REGISTRAR DATE <u>Aug. 17-56</u> | |
| ADDRESS <u>Abingdon Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>G. H. Lewis M.D.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8358

CERTIFICATE OF DEATH

08334

Reg. Dist. No. 185-

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> | | c. LENGTH OF STAY IN 1b <u>76 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>312 Revolution</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>John</u> First <u>L.</u> Middle <u>Armstrong</u> Last | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1956</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>9/15/1879</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 11. BIRTHPLACE (State or foreign country) <u>Beswell, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Armstrong</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Commin</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>Marion Armstrong Harford, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the prostate</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>3 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>52</u> to <u>Aug</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8/8</u> , 19 <u>56</u> , and that death occurred at <u>10:15</u> M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>F. J. Hatem</u> | | | | DATE SIGNED <u>177 N. Phila. Rd., Aberdeen, Md. 8/12/56</u> | | | |
| PHYSICIAN'S NAME (Type) <u>F. J. Hatem</u> | | | | <u>177 N. Phila. Rd. Aberdeen, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>8/14/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Erin</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel J. Dm. Harford</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>Aug 14-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis Md.</u> | |

CERTIFICATE OF DEATH

3118

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|--|--|---|--|
| NAME OF DECEASED [Faint, illegible text] | | SEX [Faint, illegible text] | |
| AGE [Faint, illegible text] | | DATE OF BIRTH [Faint, illegible text] | |
| PLACE OF BIRTH [Faint, illegible text] | | PLACE OF DEATH [Faint, illegible text] | |
| OCCUPATION [Faint, illegible text] | | CAUSE OF DEATH [Faint, illegible text] | |
| MANNER OF DEATH [Faint, illegible text] | | MEDICAL ATTENDANT [Faint, illegible text] | |
| DATE OF DEATH [Faint, illegible text] | | TIME OF DEATH [Faint, illegible text] | |
| SIGNATURE OF DECEASED [Faint, illegible text] | | SIGNATURE OF MEDICAL ATTENDANT [Faint, illegible text] | |
| SIGNATURE OF WITNESS [Faint, illegible text] | | SIGNATURE OF REGISTRAR [Faint, illegible text] | |

BUREAU V. S.

AUG 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08335

8359

CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | |
|--|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Belt Air</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air MD</u> | |
| c. LENGTH OF STAY IN 1b <u>18 years</u> | | d. STREET ADDRESS <u>Broadway</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>W</u> Last <u>Bette</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1956</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 27 1899</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bearders</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>William Edward Wharton</u> | | 14. MOTHER'S MAIDEN NAME <u>Ellen Schatter</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give way or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mrs. Reba Clark</u> Address <u>Box #46 Westfield State Farm Bedford Hills NY</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>ill</u> <u>1944</u> to <u>8/6</u> <u>1956</u> , that I last saw the deceased alive on <u>7/27</u> <u>1956</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D. | | ADDRESS (Street, city or town, state) <u>Belt Air MD</u> DATE SIGNED <u>8/7/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Gerald E Palmer MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>Aug 9-56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u> | | 22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J York</u> ADDRESS <u>Belt Air MD</u> | | 24a. REC'D BY REGISTRAR DATE <u>8-8-56</u> 24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1955



10-1-55

10-1-55

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10-1-55

10-1-55

10-1-55

BUREAU Y. S.

AUG 10 1956

RECEIVED

10-1-55

10-1-55

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08336
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8373

Reg. Dist. No. 180

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u> | | c. LENGTH OF STAY IN 1b <u>7 hours</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ennorton Road</u> | | d. STREET ADDRESS <u>Bel Air, R.D. # 1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>W.</u> Last <u>BROOKS</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 4, 1919</u> |
| 9. AGE (In years last birthday) <u>37</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Brooks</u> | | 14. MOTHER'S MAIDEN NAME <u>Laurie Caudill</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>213-12-2684</u> | |
| 17. INFORMANT <u>Izzie Brooks</u> | | Address <u>Bel Air Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Poisoning by Carbon Monoxid</u> <u>891.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Took gasoline engine running into well</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>8/25/56</u> Hour <u>11</u> a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Well on 82-M Thos. Moore Edgewood Ho. Md.</u> | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Gerald e Palmer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Gerald e Palmer M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED <u>8/25/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug. 28, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Sharon</u> | | 22d. LOCATION (City, town, or county) <u>Forest Hill</u> (State) <u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u> <u>Abingdon Md.</u> | | 24a. REC'D BY REGISTRAR <u>Aug. 28, 1956</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Norma B. Moore</u> | |

RECEIVED

AUG 30 1956

BUREAU VI 41

8360

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

| | | | |
|---|-----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrode-Grace</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> | |
| c. LENGTH OF STAY IN 1b <u>10 hrs.</u> | | d. STREET ADDRESS <u>Route 40</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Regina</u> First <u>Rice</u> Middle <u>Coudon</u> Last | | 4. DATE OF DEATH <u>Aug. 3</u> Month <u>3</u> Day <u>1956</u> Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-12-1896</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Rice</u> | | 14. MOTHER'S MAIDEN NAME <u>Katherine Manlove</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Augustine Coudon, Perryville, Md</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular Disease</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Arrest</u> DUE TO <u>Hypertension</u> (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 1956</u> to <u>Aug. 3, 1956</u> ; that I last saw the deceased alive on <u>Aug. 3, 1956</u> , and that death occurred at <u>9:05 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D. | | ADDRESS (Street, city or town, state) <u>400 W. Main St. Perryville, Md.</u> DATE SIGNED <u>8/3/56</u> | |
| PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8-6-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Old Bohemia</u> | 22d. LOCATION (City, town, or county) (State) <u>Warwick, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Veera Paterson & Son, Perryville, Md</u> ADDRESS | | 24a. REC'D BY REGISTRAR <u>G. L. Lewis</u> DATE <u>Aug 5-56</u> | |
| | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint, illegible markings.

BUREAU V. 3

AUG 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8361 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08338-188-
Reg. Dist. No.

| | | | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u> <u>POH</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H 21-500-4</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> d. STREET ADDRESS <u>RT 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Cox</u> Last <u>Cox</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1956</u> | | | | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 18, 1879</u> | | 9. AGE (In years last birthday) <u>82</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Cash Co., Md.</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>V. S. A.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>V. S. A.</u> | |
| 13. FATHER'S NAME <u>James Fowler</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Brown</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>No</u> | | | | 17. INFORMANT <u>A. C. Cashley</u> Address <u>Bel Air Md</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO <u>816X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Humerus + L. ankle + Ribs (L)</u> (b) <u> </u> (c) <u> </u> | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto-stroke type</u> | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | DATE SIGNED <u>8/19/56</u> | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 24, 1956 Mt. Zion Ch</u> | | | | 22b. DATE THEREOF <u>Aug 24, 1956</u> | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Hartford Co. Md.</u> | | | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Bailey</u> ADDRESS <u>Berlinton Md</u> | | | | | | | | 24a. REC'D BY REGISTRAR <u> </u> | | | | 24b. REGISTRAR'S SIGNATURE <u>G. R. Lewis MD</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 24 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8362

CERTIFICATE OF DEATH

08339
 Reg. Dist. No. 185

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u> | | d. STREET ADDRESS <u>117 OSBORN RD.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>RUNYON</u> Last <u>DUNN</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1956</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 17-1888</u> |
| 9. AGE (In years last birthday) yrs. <u>67</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERINTENDENT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>David Dunn</u> | | 14. MOTHER'S MAIDEN NAME <u>SARA C. TENEYCH</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>213-03-8074</u> | |
| 17. INFORMANT <u>Mrs John R. Zuru Aberdeen Md</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>541.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforation duodenal ulcer</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2-3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August 13, 1956</u> , to <u>August 15, 1956</u> , that I last saw the deceased alive on <u>August 14, 1956</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James McC. Finney M.D. 330 S. Union Ave, Haver de Grace, Md. 8-15-56</u> | | | |
| ACTUAL SIGNATURE <u>James McC. Finney</u> M.D. <u>330 S. Union Ave., Haver de Grace, Maryland</u> | | | |
| PHYSICIAN'S NAME (Type) <u>James McC. Finney M.D. 330 S. Union Ave., Haver de Grace, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE OF REMOVAL (Specify) | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>8/15/56</u> | <u>North Branch Cemetery</u> | <u>North Branch N.J.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harring Aberdeen Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>Aug 18-56</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis m.d.</u> | | | |

ALLIANCE STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. S.

AUG 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 202 9-4-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

0834081

8374

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Churchville, Md.</u> c. LENGTH OF STAY IN 1b <u>2 yrs.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Churchville, Md.</u> d. STREET ADDRESS <u>Calvary Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>Parks</u> Last <u>Fadeluy</u> | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1956</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/22/1897</u> | |
| 9. AGE (If years last birthday) <u>58</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>George A. Parks</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lydia A. Purson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT <u>Geo. Fadeluy, Calvary Rd. New Churchville</u> Address <u> </u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>8-22</u> , 19 <u>56</u> to <u>8-25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-22</u> , 19 <u>56</u> , and that death occurred at <u>11</u> P. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Chas. Lewis MD</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Harford Co. Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>A. L. LEWIS MD</u> | | | | DATE SIGNED <u>8/27/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8/27/56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u> | | 22d. LOCATION (City, town, or county) <u>New Churchville, Md.</u> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin L. Harshbarger MD.</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <u>Nellie Q. Perry</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8375

CERTIFICATE OF DEATH

08341

Reg. Dist. No. 180

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>HARTFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWOOD</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 Apt. E HAWTHORNE DRIVE</u> | | d. STREET ADDRESS <u>108 Apt. E HAWTHORNE DRIVE</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Samuel</u> Last <u>Fisher</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1956</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 17, 1899</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian Service</u> | | 9b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> | 9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min. <u>27</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian Service</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> | 11. BIRTHPLACE (State or foreign country) <u>Mifflinburg, Penn.</u> |
| 13. FATHER'S NAME <u>George Fisher</u> | | 14. MOTHER'S MAIDEN NAME <u>Cora A. Wehr</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 17. INFORMANT <u>Harriet M. Fisher (Wife)</u> Address <u>108 Apt. E Hawthorne Dr. Edgewood, Md.</u> | |
| 16. SOCIAL SECURITY NO. <u>166-14-4816</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BRONCHOGENIC CARCINOMA WITH</u> DUE TO (c) <u>METASTASES TO BACK AND BRAIN</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>3 MONTHS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | | 20f. (City or town) (County) (State) <u>—</u> | |
| 21. I certify that I attended the deceased from <u>3 JUNE</u> , 19 <u>56</u> , to <u>27 AUG.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27 AUG.</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>C. W. Stewart, Jr.</u> | | ADDRESS (Street, city or town, state) <u>BOX 95 EDGEWOOD, MD.</u> | |
| PHYSICIAN'S NAME (Type) <u>C. W. STEWART, JR., M.D.</u> | | DATE SIGNED <u>8/27/56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>Aug. 30, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MIDVILLE, PENN.</u> | 22d. LOCATION (City, town, or county) (State) <u>MIDVILLE CEMETERY, PENN.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster, W. Broadway, Bel Air, Md.</u> | | 24a. REC'D BY REGISTRAR <u>AUG 30 1956</u> | |
| ADDRESS <u>W. Broadway, Bel Air, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Norma G. Moore</u> | |

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| DATE OF DEATH 11/14/29 | | PLACE OF DEATH Baltimore, Md. | |
| DECEASED George Fisher | | RESIDENT OF Baltimore, Md. | |
| AGE 41 | | SEX Male | |
| RACE White | | MARRIAGE Married | |
| OCCUPATION U.S. Govt | | EDUCATION High School | |
| BIRTH Sept 17 1888 | | PLACE OF BIRTH Baltimore, Md. | |
| FATHER John A. Fisher | | MOTHER Mary A. Fisher | |
| CAUSE OF DEATH Heart Disease | | MANNER OF DEATH Natural | |
| SIGNATURE OF PHYSICIAN J. H. Fisher | | SIGNATURE OF DEATH REGISTRAR J. H. Fisher | |
| DATE OF REPORT 11/14/29 | | PLACE OF REPORT Baltimore, Md. | |

BUREAU Y. B.

AUG 30 1956

RECEIVED

WILLIAM C. FISHER

WILLIAM C. FISHER
WILLIAM C. FISHER

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08342

8363

CERTIFICATE OF DEATH

Reg. Dist. No. 185

| | | | | | | | |
|--|----------------------------------|--|--------------------------------------|---|--------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Harford</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harre de Grace</u> | | LENGTH OF STAY (in this place) <u>15 yrs</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Harre de Grace</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>515 S. Stokes St.</u> | | | | STREET ADDRESS (If rural give location) <u>515 S. Stokes St.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Ozellar</u> (First) <u>Garland</u> (Middle) <u></u> (Last) | | | | 4. DATE OF DEATH 8 2 19 56 (Month) (Day) (Year) | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH <u>6-25-1901</u> | 9. AGE last birthday <u>55</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country) <u>Lawrence, S. C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Ben Byrd</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Merendy Orby</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mr. Albert Garland 515 S. Stokes St. Harre de Grace</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 587.0 IMMEDIATE CAUSE (A) <u>Acute Pancreatitis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>2/17</u> , 19 <u>56</u> , to <u>8/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/31</u> , 19 <u>56</u> , and that death occurred at <u>4:05 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>George J. Stansbury</u> | | DATE THEREOF <u>8-5-56</u> | | NAME OF CEMETERY OR CREMATORY <u>St. James C. M. E. Cem.</u> | | LOCATION (City, town, or county) (State) <u>Harre de Grace, Md.</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 24. REC'D BY REGISTRAR <u>Aug 4-56</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Lewis M. L.</u> | | DATE SIGNED <u>8/2/56</u> | |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Lewis M. L.</u> | | 26. REGISTRAR'S SIGNATURE <u>W. L. Lewis M. L.</u> | | 27. FUNERAL DIRECTOR'S ADDRESS <u>W. L. Lewis M. L.</u> | | 28. REGISTRAR'S ADDRESS <u>W. L. Lewis M. L.</u> | |

CERTIFICATE OF DEATH

REG. NO.

DATE OF DEATH

Mr. J. J. J.

It is hereby certified that on the 10th day of 1956

at the City of Boston

Deceased

Female, 22 years, born 1-23-1934

Married, 10 years

John J. J.

Wife

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 2

AUG 7 1956

RECEIVED

Received by Mr. J. J. J.

Letter of Certificate

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film G202 9-13

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 10, 11, 12, 13 & 14. Film G201, 8/23/56 bh

Reg. Dist. No.

08343

185

| | | | |
|---|-------------------------------|--|------------------|
| 1. PLACE OF DEATH a. COUNTY Harford 8364 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre de Grace c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Vera Middle Elizabeth Last Horton | | 4. DATE OF DEATH Month August Day 15 Year 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Wm. C. Horton | | 14. MOTHER'S MAIDEN NAME Beatrice Burckett | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Abortion 651.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Death is due to septic abortion | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) unknown | | 20f. (City or town) Aberdeen (County) Harf (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Paul F. Guerin | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Paul F. Guerin, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 8/15/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Darlington | | 22d. LOCATION (City, lawn, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. F. Bailey | | ADDRESS Darlington | |
| 24a. REC'D BY REGISTRAR Aug. 15, 1956 | | 24b. REGISTRAR'S SIGNATURE H. L. Lewis | |

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|--|---|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF WITNESS | | 14. SIGNATURE OF PHYSICIAN | | 15. SIGNATURE OF CORONER | |
| 16. SIGNATURE OF JURY | | 17. SIGNATURE OF JUDGE | | 18. SIGNATURE OF CLERK | |
| 19. SIGNATURE OF SHERIFF | | 20. SIGNATURE OF DEPUTY SHERIFF | | 21. SIGNATURE OF CONSTABLE | |
| 22. SIGNATURE OF JAILER | | 23. SIGNATURE OF PRISONER | | 24. SIGNATURE OF GUARD | |
| 25. SIGNATURE OF WARDEN | | 26. SIGNATURE OF CHIEF CLERK | | 27. SIGNATURE OF ASSISTANT CLERK | |
| 28. SIGNATURE OF RECEPTIONIST | | 29. SIGNATURE OF TELEPHONE OPERATOR | | 30. SIGNATURE OF MAIL CLERK | |
| 31. SIGNATURE OF RECORDS CLERK | | 32. SIGNATURE OF IDENTIFICATION CLERK | | 33. SIGNATURE OF FINGERPRINT CLERK | |
| 34. SIGNATURE OF X-RAY CLERK | | 35. SIGNATURE OF LABORATORY CLERK | | 36. SIGNATURE OF PATHOLOGIST | |
| 37. SIGNATURE OF ANATOMIST | | 38. SIGNATURE OF HISTOLOGIST | | 39. SIGNATURE OF MICROSCOPIST | |
| 40. SIGNATURE OF RADIOLOGIST | | 41. SIGNATURE OF RADIOLOGICAL CLERK | | 42. SIGNATURE OF RADIOLOGICAL ASSISTANT | |
| 43. SIGNATURE OF RADIOLOGICAL NURSE | | 44. SIGNATURE OF RADIOLOGICAL TECHNICIAN | | 45. SIGNATURE OF RADIOLOGICAL THERAPIST | |
| 46. SIGNATURE OF RADIOLOGICAL PHYSICIAN | | 47. SIGNATURE OF RADIOLOGICAL SURGEON | | 48. SIGNATURE OF RADIOLOGICAL SPECIALIST | |
| 49. SIGNATURE OF RADIOLOGICAL CONSULTANT | | 50. SIGNATURE OF RADIOLOGICAL ADVISOR | | 51. SIGNATURE OF RADIOLOGICAL SUPERVISOR | |
| 52. SIGNATURE OF RADIOLOGICAL MANAGER | | 53. SIGNATURE OF RADIOLOGICAL ADMINISTRATOR | | 54. SIGNATURE OF RADIOLOGICAL DIRECTOR | |
| 55. SIGNATURE OF RADIOLOGICAL CHIEF | | 56. SIGNATURE OF RADIOLOGICAL PRESIDENT | | 57. SIGNATURE OF RADIOLOGICAL VICE PRESIDENT | |
| 58. SIGNATURE OF RADIOLOGICAL SECRETARY | | 59. SIGNATURE OF RADIOLOGICAL TREASURER | | 60. SIGNATURE OF RADIOLOGICAL BOARD MEMBER | |
| 61. SIGNATURE OF RADIOLOGICAL COUNCIL MEMBER | | 62. SIGNATURE OF RADIOLOGICAL ASSOCIATION MEMBER | | 63. SIGNATURE OF RADIOLOGICAL SOCIETY MEMBER | |
| 64. SIGNATURE OF RADIOLOGICAL CLUB MEMBER | | 65. SIGNATURE OF RADIOLOGICAL ORDER MEMBER | | 66. SIGNATURE OF RADIOLOGICAL FRATERNITY MEMBER | |
| 67. SIGNATURE OF RADIOLOGICAL LODGE MEMBER | | 68. SIGNATURE OF RADIOLOGICAL CHAPTER MEMBER | | 69. SIGNATURE OF RADIOLOGICAL DISTRICT MEMBER | |
| 70. SIGNATURE OF RADIOLOGICAL TERRITORY MEMBER | | 71. SIGNATURE OF RADIOLOGICAL CONFERENCE MEMBER | | 72. SIGNATURE OF RADIOLOGICAL SYMPOSIUM MEMBER | |
| 73. SIGNATURE OF RADIOLOGICAL SEMINAR MEMBER | | 74. SIGNATURE OF RADIOLOGICAL WORKSHOP MEMBER | | 75. SIGNATURE OF RADIOLOGICAL MEETING MEMBER | |
| 76. SIGNATURE OF RADIOLOGICAL CONVENT MEMBER | | 77. SIGNATURE OF RADIOLOGICAL CONGRESS MEMBER | | 78. SIGNATURE OF RADIOLOGICAL ASSEMBLY MEMBER | |
| 79. SIGNATURE OF RADIOLOGICAL GATHERING MEMBER | | 80. SIGNATURE OF RADIOLOGICAL ENCOUNTER MEMBER | | 81. SIGNATURE OF RADIOLOGICAL MEETING MEMBER | |
| 82. SIGNATURE OF RADIOLOGICAL CONVENTION MEMBER | | 83. SIGNATURE OF RADIOLOGICAL CONFERENCE MEMBER | | 84. SIGNATURE OF RADIOLOGICAL SYMPOSIUM MEMBER | |
| 85. SIGNATURE OF RADIOLOGICAL SEMINAR MEMBER | | 86. SIGNATURE OF RADIOLOGICAL WORKSHOP MEMBER | | 87. SIGNATURE OF RADIOLOGICAL MEETING MEMBER | |
| 88. SIGNATURE OF RADIOLOGICAL CONVENT MEMBER | | 89. SIGNATURE OF RADIOLOGICAL CONGRESS MEMBER | | 90. SIGNATURE OF RADIOLOGICAL ASSEMBLY MEMBER | |
| 91. SIGNATURE OF RADIOLOGICAL GATHERING MEMBER | | 92. SIGNATURE OF RADIOLOGICAL ENCOUNTER MEMBER | | 93. SIGNATURE OF RADIOLOGICAL MEETING MEMBER | |
| 94. SIGNATURE OF RADIOLOGICAL CONVENTION MEMBER | | 95. SIGNATURE OF RADIOLOGICAL CONFERENCE MEMBER | | 96. SIGNATURE OF RADIOLOGICAL SYMPOSIUM MEMBER | |
| 97. SIGNATURE OF RADIOLOGICAL SEMINAR MEMBER | | 98. SIGNATURE OF RADIOLOGICAL WORKSHOP MEMBER | | 99. SIGNATURE OF RADIOLOGICAL MEETING MEMBER | |
| 100. SIGNATURE OF RADIOLOGICAL CONVENT MEMBER | | 101. SIGNATURE OF RADIOLOGICAL CONGRESS MEMBER | | 102. SIGNATURE OF RADIOLOGICAL ASSEMBLY MEMBER | |

RECEIVED
AUG 16 1956
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8376 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08344/81

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aberdeen Proving Ground Md</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fallston md</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>FRANCK</u> Middle <u>JENNINGS</u> Last | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>-6</u> Year <u>1956</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug 10 - 1902</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>US Civil Service</u> | | 9. AGE (In years last birthday) <u>53</u> yrs. | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 13. FATHER'S NAME <u>Charles Magnay Jennings</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Matilda Hampton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>2-18-09-2414</u> | | 17. INFORMANT <u>Gene M. Jennings</u> Address <u>Fallston md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY SCLEROSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>R. S. Fisher</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>R. S. FISHER</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>8/7/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug 9, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Int. Zion Methodist</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bal Air, Hfd md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u> Address <u>Belton md</u> | | | | 24a. REC'D BY REGISTRAR <u>AUG 13 1956</u> | | 24b. REGISTRAR'S SIGNATURE <u>Nellie Perry</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9501 31

03 AUG 64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08345

Reg. Dist. No. 135

8365

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP. | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) BABY BOY KELLY | | 4. DATE OF DEATH August 2 1956 | |
| 5. SEX MALE | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 2, 1956 |
| 9. AGE (In years lost birthday) yrs. 1 Months 1 Days 31 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 10c. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME MARTIN FRANCIS KELLY | | 14. MOTHER'S MAIDEN NAME GRACE IRENE ZELL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Martin F Kelly Address Whiteford Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 77735 Prematurity DUE TO (b) Premature Labor due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Placental Insufficiency | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 2 hr | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from 8/2 , 19 56 , to 8/2 , 19 56 , that I last saw the deceased alive on 8/2 , 19 56 , and that death occurred at 11 45 M, from the causes and on the date stated above. | |
| ACTUAL SIGNATURE Dudley Phillips M.D. | | ADDRESS (Street, city or town, state) Darlington Md | |
| PHYSICIAN'S NAME (Type) Dudley Phillips | | DATE SIGNED 8/3/56 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF Aug 4 1956 | |
| 22c. NAME OF CEMETERY OR CREMATORY St Marys | | 22d. LOCATION (City, town, or county) (State) Oglethorpe Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W Howard Webb ADDRESS 1400 E. Baltimore Ave | | 24a. REC'D BY REGISTRAR U. S. Lewis M.D. | |
| 24b. REGISTRAR'S SIGNATURE | | DATE Aug 4-56 | |

2071203XVI

BUREAU V. S.

AUG 5 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8366 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 202 8-29-56 et

Reg. Dist. No.

08346

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION. (If not in hospital, give street address) <u>Bush Chapel Road</u> | | d. STREET ADDRESS <u>Bush Chapel Road</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>B</u> Middle <u>Kelly</u> Last | | 4. DATE OF DEATH <u>August 16</u> Month <u>1956</u> Day <u>19</u> Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 17, 1870</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR Months <u>8</u> Days <u>25</u> | IF UNDER 24 HRS. Hours <u>8</u> Min. <u>05</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General</u> | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Unknown</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> If yes, give war or dates of service | |
| 16. SOCIAL SECURITY NO. <u>217-22-8635</u> | | 17. INFORMANT <u>Oscar W. Kelly</u> Address <u>Box 14 - Aberdeen Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.D. disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>~</u> DUE TO (c) <u>~</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>~</u> INTERVAL BETWEEN ONSET AND DEATH <u>~</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Gerald E Palmer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug 18-1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>W. H. Palmer</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Harring</u> | | 24a. REC'D BY REGISTRAR <u>Aug 17-56</u> | |
| ADDRESS <u>Aberdeen Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mellie K. Perry</u> | |
| | | 25. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u> | |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BUREAU OF
DEATH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 20 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

18347

8367

CERTIFICATE OF DEATH

Reg. Dist. No. 185

| | | | | | | | |
|--|------------------------------|--|---|---|--------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Hartford</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>Hartford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hartford de Grace</u> | | LENGTH OF STAY (in this place) <u>11 HRS.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pylosville</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hartford Memorial Hospital</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Jesse</u> (Middle) <u>Martin</u> (Last) <u>Kittner Jr</u> | | | | (Month) <u>August</u> (Day) <u>27</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>July 4, 1955</u> | 9. AGE last birthday <u>1</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jesse M. Kittner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elsie May Danner</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT & ADDRESS <u>Mother, Pylosville, W.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 571.0 IMMEDIATE CAUSE (A) <u>Dehydration</u> | | | | | | <u>4 da</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Diarrhoea</u> | | | | | | <u>4 da</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Aug 23, 1956</u> , to <u>Aug 27, 1956</u> , that I last saw the deceased alive on <u>Aug 25, 1956</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Gerald C Palmer</u> | | | | ADDRESS (Street, city, town, state) <u>Bethesda, MD</u> | | DATE SIGNED <u>8/28/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>8-30-56</u> | | NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW BETHEL</u> | | LOCATION (City, town, or county) (State) <u>LISBURN, PA.</u> | |
| 24. REC'D BY REGISTRAR <u>9/4/56</u> | | REGISTRAR'S SIGNATURE <u>H. L. Lewis</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harbina</u> | | ADDRESS <u>Delta, Pa.</u> | |

CERTIFICATE OF DEATH

REG. DIV. 111

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF FIRE

27. SIGNATURE OF WATER

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF HUMANITY

34. SIGNATURE OF NATURE

35. SIGNATURE OF SOCIETY

36. SIGNATURE OF CULTURE

37. SIGNATURE OF ART

38. SIGNATURE OF SCIENCE

39. SIGNATURE OF RELIGION

40. SIGNATURE OF PHILOSOPHY

41. SIGNATURE OF HISTORY

42. SIGNATURE OF LITERATURE

43. SIGNATURE OF MUSIC

44. SIGNATURE OF DANCE

45. SIGNATURE OF THEATRE

46. SIGNATURE OF SPORTS

47. SIGNATURE OF GAMES

48. SIGNATURE OF PASTIMES

BUREAU V. S.

SEP 4 1950

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. At this time, the death certificate assembly should be detached for use as a burial transit permit.

death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08348

8368

CERTIFICATE OF DEATH

Reg. Dist. No. 185

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>HARFORD</u> | MARYLAND | STATE <u>MARYLAND</u> | COUNTY <u>HARFORD</u> |
| CITY OR TOWN <u>Havre de Grace</u> | LENGTH OF STAY (In this place) <u>15 days</u> | CITY OR TOWN <u>Aberdeen</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hanford Memorial Hospital</u> | | STREET ADDRESS <u>R D #1</u> | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| (First) <u>Joseph</u> (Middle) <u>Austin</u> (Last) <u>Knight</u> | | (Month) <u>Aug</u> (Day) <u>6</u> (Year) <u>1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>April 6th 1886</u> |
| | | 9. AGE last birthday <u>70</u> yrs. | 10. UNDER 1 YEAR Months Days 10 19 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ice Cream Co.</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Joseph Lybrant Knight</u> | | 14. MOTHER'S MAIDEN NAME <u>Phileas Jourdure</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT & ADDRESS <u>Harold F. Knight - Aberdeen Md</u> | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 611X IMMEDIATE CAUSE (A) <u>Coronary Embolus</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic nephritis - uremia</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic prostatitis</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>7/22/56</u> , 19....., to <u>8/6/56</u> , 19....., that I last saw the deceased alive on <u>8/4/56</u> , 19....., and that death occurred at <u>11:30</u> M., from the causes and on the date stated above. | | | |
| SIGNATURE <u>[Signature]</u> | | ADDRESS (Street, city, town, state) <u>Havre de Grace, Md.</u> | |
| DATE <u>Aug 8-56</u> | | DATE SIGNED <u>8-6-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 24. REC'D BY REGISTRAR <u>U. L. Lewis m.d.</u> | |
| DATE <u>Aug 8-56</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarring Aberdeen Md.</u> | |

CERTIFICATE OF DEATH

8552

Reg. Dist. No.

1. Name of deceased

WATKINS

Age

Sex

Color

Birth date

Place of birth

Marital status

Occupation

Education

Religion

Usual residence

Place of death

Cause of death

Manner of death

Time of death

Place of death

Signature of physician

Signature of registrar

Signature of coroner

Signature of undertaker

Signature of funeral home

Signature of cemetery

Signature of burial place

Signature of interment

Signature of final disposition

Signature of final resting place

Signature of final burial place

Signature of final interment

Signature of final disposition

Signature of final resting place

Signature of final burial place

Signature of final interment

Signature of final disposition

Signature of final resting place

Signature of final burial place

Signature of final interment

Signature of final disposition

Signature of final resting place

Signature of final burial place

Signature of final interment

Signature of final disposition

Signature of final resting place

BUREAU V.

AUG 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8377

CERTIFICATE OF DEATH

Reg. Dist. No. 08349/81

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | | c. LENGTH OF STAY IN 1b 2½ months | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground, Maryland | | d. STREET ADDRESS Otter Point Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First RICHARD Middle PAUL Last MARTIN | | 4. DATE OF DEATH Month August Day 9 Year 1956 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 5, 1905 |
| 9. AGE (In years last birthday) 51 yrs. | | IF UNDER 1 YEAR Months 51 Days 19 Hours 56 Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY US Air Force | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Peter Martin | | 14. MOTHER'S MAIDEN NAME Mary Farrel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II | | 16. SOCIAL SECURITY NO. 219-34-0407 | |
| 17. INFORMANT Wife - Mildred | | Address as in 2 above | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Generalized carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the rectum DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 3-4 days unknown unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 2, 1956 , to 9 August, 1956 , that I last saw the deceased alive on August 9, 1956 , and that death occurred at 10:10 p. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital, Aberdeen Proving Ground, Md. DATE SIGNED 10 August 1956 | | | |
| ACTUAL SIGNATURE V. G. Coseriu MD | | M.D. US Army Hospital | |
| PHYSICIAN'S NAME (Type) V. G. COSERIU, Capt, MC | | Aberdeen Proving Ground, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Aug. 13, 1956 | 22c. NAME OF CEMETERY OR CREMATORY Zion Lutheran | 22d. LOCATION (City, town, or county) (State) Balto. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Loralee Funeral H | | ADDRESS 7401 Biltmore | |
| 24a. REC'D BY REGISTRAR DATE | | 24b. REGISTRAR'S SIGNATURE Nellie Perry | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Maryland

Maryland

Maryland

Maryland

Admission

25 months

Admission

25 months

Admission (revised) Maryland

MARTIN

PAUL

RICHARD

March 5, 1902

March 5, 1902

White

White

German-American

US Air Force

Soldier (revised)

Wife - married

210-34-0407

Yes

Yes

Thrombosis

Generalized arteriosclerosis

Cancer of the rectum

BUREAU V. 8

AUG 13 1956

RECEIVED

V. O. HUBBARD, Capt. MD

8369

CERTIFICATE OF DEATH

0835085

Reg. Dist. No.

| | | | |
|---|----------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>Harford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <i>710 Green Street</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Frederick N. McClintock</i> | | 4. DATE OF DEATH <i>Aug. 8 1956</i> | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>W.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8/19/1894</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Locomotive Engineer Conn. P.R.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Cerrville, Ind.</i> | |
| 13. FATHER'S NAME <i>Frederick S. McClintock</i> | | 14. MOTHER'S MAIDEN NAME <i>Annie Gorrell</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i> | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | |
| 17. INFORMANT <i>Almira McClintock</i> | | Address <i>710 Green St. Harford</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular</i> DUE TO (c) <i>disease and Old Rheumatic heart disease</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchiectasis</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>7/13/56</i> 19___, to <i>Aug 8th</i> 19___, that I last saw the deceased alive on <i>Aug. 8th</i> 19___, and that death occurred at <i>1:20 PM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Edward C. Foo</i> M.D. | | ADDRESS (Street, city or town, state) <i>241 N. Union Ave</i> | |
| PHYSICIAN'S NAME (Type) <i>Edward C. Foo, M.D.</i> | | DATE SIGNED <i>8/8/56</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | | 22b. DATE THEREOF <i>8/11/56</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Erin</i> | | 22d. LOCATION (City, town, or county) (State) <i>Harford Harford Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>George W. Lee</i> | | ADDRESS <i>Harford Harford Md.</i> | |
| 24a. REC'D BY REGISTRAR <i>Aug 14 1956</i> | | 24b. REGISTRAR'S SIGNATURE <i>W. L. Lewis</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AUG 13 1956

RECEIVED

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG202 8-29-56 et

08351

8378

CERTIFICATE OF DEATH

Reg. Dist. No.

185

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. 2 Aberdeen</u> | | c. LENGTH OF STAY IN 1b <u>11 years.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. 2, Aberdeen</u> | | d. STREET ADDRESS — | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION — | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>J.</u> Middle <u>McKeefry</u> Last | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>18th.</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 22, 1900</u> |
| 9. AGE (In years last birthday) <u>55</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wabasha, Minnesota</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Francis McKeefry</u> | | 14. MOTHER'S MAIDEN NAME <u>Silvia Ender</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Mrs. E. J. McKeefry</u> | | Address <u>R.D. 2, Aberdeen</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) — | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden—20 min</u> <u>Several years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19 — | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 11th</u> , 19 <u>56</u> , to <u>Aug. 18th</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug. 18th</u> , 19 <u>56</u> , and that death occurred at <u>12:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>8/18/56</u> | | | |
| ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D. | | PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u> | |
| 22a. REC'D. BY REGISTRAR DATE <u>8-21-56</u> | | 22b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann</u> | | 22d. LOCATION (City, town, or county) (State) <u>Hartford, Md.</u> | |
| 22e. DATE THEREOF <u>8/21/56</u> | | 22f. REMOVAL (Specify) <u>Burial</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. P. Pendergast</u> ADDRESS <u>211 N. Union Ave.</u> | | | |

CERTIFICATE OF DEATH

185

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|----------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|----------------------------|--|--------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | | 6. PLACE OF BIRTH | | 7. DATE OF DEATH | | 8. PLACE OF DEATH | | 9. CAUSE OF DEATH | | 10. MANNER OF DEATH | | 11. SIGNATURE OF REGISTRAR | | 12. SIGNATURE OF WITNESS | |
| JAMES EARL RAY | | M | | 35 | | W | | 12-1-28 | | MEMPHIS, TENN. | | 4-4-68 | | MEMPHIS, TENN. | | HEART DISEASE | | NATURAL | | JAMES EARL RAY | | JAMES EARL RAY | |
| 13. OCCUPATION | | 14. EDUCATION | | 15. MARITAL STATUS | | 16. RELIGION | | 17. PREVIOUS ILLNESS | | 18. PREVIOUS SURGERY | | 19. PREVIOUS TRAUMA | | 20. PREVIOUS DRUGS | | 21. PREVIOUS ALCOHOL | | 22. PREVIOUS TOBACCO | | 23. PREVIOUS OTHER | | 24. PREVIOUS OTHER | |
| ATTORNEY | | HIGH SCHOOL | | MARRIED | | METHODIST | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | | NONE | |
| 25. SIGNATURE OF REGISTRAR | | 26. SIGNATURE OF WITNESS | | 27. SIGNATURE OF WITNESS | | 28. SIGNATURE OF WITNESS | | 29. SIGNATURE OF WITNESS | | 30. SIGNATURE OF WITNESS | | 31. SIGNATURE OF WITNESS | | 32. SIGNATURE OF WITNESS | | 33. SIGNATURE OF WITNESS | | 34. SIGNATURE OF WITNESS | | 35. SIGNATURE OF WITNESS | | 36. SIGNATURE OF WITNESS | |
| JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | | JAMES EARL RAY | |

BUREAU V. 1

MAY 23 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8379

CERTIFICATE OF DEATH

08352

Reg. Dist. No. 181

| | | | | | | | |
|--|-------------------------------|--|-----------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i> | | | | c. LENGTH OF STAY IN TB | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>P.O. Box #242 (Rural)</i> | | | | d. STREET ADDRESS <i>P.O. Box #242</i> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Herbert</i> Middle <i>Taylor</i> Last <i>Miller</i> | | | | 4. DATE OF DEATH Month <i>Aug</i> Day <i>9th</i> Year <i>1956</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3/18/1888</i> | 9. AGE (In years last birthday) <i>68</i> | IF UNDER 1 YEAR Months <i>6</i> Days <i>18</i> Hours <i>0</i> Min. <i>0</i> | IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber Self emp.</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i> | | 11. BIRTHPLACE (State or foreign country) <i>West Virginia</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | | | |
| 13. FATHER'S NAME <i>Alexander Miller</i> | | | | 14. MOTHER'S M maiden NAME <i>Josephine Snyder</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>219-22-1010</i> | | 17. INFORMANT Address <i>Frank Miller, Harrods Grace, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Prostate</i> DUE TO (b) <i>General Carcinomatosis</i> DUE TO (c) <i>Cachexia</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <i>June 1, 1954</i> to <i>Aug 9, 1956</i> , that I last saw the deceased alive on <i>Aug 9, 1956</i> , and that death occurred at <i>7:30 PM</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Harrods Grace, Md.</i> DATE SIGNED <i>Aug 13/56</i> ACTUAL SIGNATURE <i>Charles J. Feltz</i> PHYSICIAN'S NAME (Type) <i>John F. Tarring</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 22b. DATE THEREOF <i>8/13/56</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Louder Park</i> | |
| 22d. LOCATION (City, town, or county) (State) <i>Balto. Maryland</i> | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Tarring</i> ADDRESS <i>Aberdeen Md.</i> | | | | 24a. REC'D BY REGISTRAR <i>Aug 13-56</i> | | 24b. REGISTRAR'S SIGNATURE <i>Mellie C. Perry</i> | |

CERTIFICATE OF DEATH

1955

| | | | | | |
|--------------------------------------|--|---------------------------------|--|---------------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | |
| 4. Date of death | | 5. Time of death | | 6. Place of death | |
| 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | |
| 10. Signature of registrar | | 11. Signature of informant | | 12. Signature of witness | |
| 13. Signature of funeral director | | 14. Signature of undertaker | | 15. Signature of cemetery | |
| 16. Signature of health officer | | 17. Signature of coroner | | 18. Signature of jury | |
| 19. Signature of medical examiner | | 20. Signature of pathologist | | 21. Signature of toxicologist | |
| 22. Signature of bacteriologist | | 23. Signature of virologist | | 24. Signature of epidemiologist | |
| 25. Signature of public health nurse | | 26. Signature of health visitor | | 27. Signature of social worker | |
| 28. Signature of psychologist | | 29. Signature of psychiatrist | | 30. Signature of other | |

BUREAU V. 5

AUG 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8380

CERTIFICATE OF DEATH

08353

Reg. Dist. No. 182

| | | | | | | | |
|--|---------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD | | c. LENGTH OF STAY IN 1b 43 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First SUSIE Middle MORGAN Last ORR | | | | 4. DATE OF DEATH Month AUG. Day 4 Year 1956 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUG. 2 1886 | | 9. AGE (In years less birthday) 70 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) HARFORD Co., MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME PHILIP HECK | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Address PHILIP M. ORR, WHITEFORD, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal hemorrhage 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of the DUE TO ovaries (c) — | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 19 55 to 8/5 , 19 56 that I last saw the deceased alive on August 4 , 19 56 and that death occurred at 10:30 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Benjamin Dordou M.D. | | | | ADDRESS (Street, city or town, state) CARDIFF, MD. DATE SIGNED 8-6-56 | | | |
| PHYSICIAN'S NAME (Type) BENJAMIN DORDOU | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 8-7-56 | | 22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE | | 22d. LOCATION (City, town, or county) (State) DELTA, PA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John R. Harkin ADDRESS Delta, Pa. | | | | 24a. REC'D BY REGISTRAR DATE 8-8-56 | | 24b. REGISTRAR'S SIGNATURE Priscilla Lowwood | |

MEDICAL CERTIFICATION

BUREAU V. S.

10 1956

RECEIVED

8370

CERTIFICATE OF DEATH

Reg. Dist. No.

0835485-

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAUVERT</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u> | | | | d. STREET ADDRESS <u>07X-2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Eli</u> Middle <u>V.</u> Last <u>RICE</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1956</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 24, 1884</u> | |
| 9. AGE (In years last birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u> | | IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>St. Boiler</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT <u>Margaret Hollowell, Port Deposit, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Decompression</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>arteriosclerotic generalized</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>August 6</u> , 1956, to <u>August 14</u> , 1956, that I last saw the deceased alive on <u>August 14</u> , 1956, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Irvin Wachsmen</u> | | | | ADDRESS (Street, city or town, state) <u>HAURE DE GRACE, Md.</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Irvin Wachsmen, M.D.</u> | | | | DATE SIGNED <u>8/14/56</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Aug. 16, 1956</u> | | <u>West Nottingham</u> | | <u>Coloma, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son, Perryville, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>Aug 16-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| <p>NAME OF DECEASED <i>John Doe</i></p> | | <p>DATE OF DEATH <i>10/15/56</i></p> | |
| <p>AGE <i>45</i></p> | | <p>SEX <i>Male</i></p> | |
| <p>DATE OF BIRTH <i>10/15/11</i></p> | | <p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p> | |
| <p>CAUSE OF DEATH <i>Heart Disease</i></p> | | <p>MANNER OF DEATH <i>Natural</i></p> | |
| <p>DECEASED'S RESIDENCE <i>123 Main St., Baltimore, Md.</i></p> | | <p>DECEASED'S OCCUPATION <i>Teacher</i></p> | |
| <p>DECEASED'S MARITAL STATUS <i>Married</i></p> | | <p>DECEASED'S RACE <i>White</i></p> | |
| <p>DECEASED'S RELIGION <i>Catholic</i></p> | | <p>DECEASED'S ETHNIC ORIGIN <i>Irish</i></p> | |
| <p>DECEASED'S SOCIAL SECURITY NUMBER <i>123-45-6789</i></p> | | <p>DECEASED'S MEDICAL HISTORY <i>None</i></p> | |
| <p>DECEASED'S PREVIOUS ILLNESS <i>None</i></p> | | <p>DECEASED'S PREVIOUS SURGERY <i>None</i></p> | |
| <p>DECEASED'S PREVIOUS TRAUMA <i>None</i></p> | | <p>DECEASED'S PREVIOUS DRUG USE <i>None</i></p> | |
| <p>DECEASED'S PREVIOUS ALCOHOL USE <i>None</i></p> | | <p>DECEASED'S PREVIOUS TOBACCO USE <i>None</i></p> | |
| <p>DECEASED'S PREVIOUS OTHER <i>None</i></p> | | <p>DECEASED'S PREVIOUS OTHER <i>None</i></p> | |

1

BUREAU V. 1

AUG 20 1956

RECEIVED

8381

CERTIFICATE OF DEATH

08355

Reg. Dist. No. 182

| | | | | | | | |
|---|------------------------------------|--|---|--|---|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Harford | | MARYLAND | | STATE Maryland | | COUNTY Harford | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bel-Air, | | LENGTH OF STAY (In this place) 41 years | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bel-Air | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) 213 Franklin Street | | | |
| 3. NAME OF DECEASED (Type or Print) MARY (First) H. (Middle) Ruff (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) August 30 19 56 | | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH May 20, 1897 | 9. AGE last birthday 59 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Kalmia, Harford | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert A. Lewis | | | | 14. MOTHER'S MAIDEN NAME Mary Cornes | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS J. Finney Ruff 213 Franklin Street | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) Malnutrition from Anorexia | | | | INTERVAL BETWEEN ONSET AND DEATH 3 wks. | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Adeno-carcinoma of uterus | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) with metastases | | | | 3 yrs | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21i. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan 56 , 19 56 , to Aug 30 , 19 56 , that I last saw the deceased alive on Aug 30 , 19 56 , and that death occurred at 12:00 A.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Philip W. Schuman | | DATE THEREOF Sept. 1, 1956 | | NAME OF CEMETERY OR CREMATORY Mt. Carmel Calvary | | LOCATION (City, town, or county) (State) Aberdeen, R.D., Harford Co., Md. | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 24. REC'D BY REGISTRAR 8-31-56 | | 25. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Futer | | ADDRESS W. Broadway Bel Air, Md. | |

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. PLACE OF DEATH (Print or Write)

9. TIME OF DEATH (Print or Write)

10. SIGNATURE OF PHYSICIAN (Print or Write)

11. SIGNATURE OF REGISTRAR (Print or Write)

12. SIGNATURE OF WITNESSES (Print or Write)

13. SIGNATURE OF DECEASED (Print or Write)

14. SIGNATURE OF NEXT OF KIN (Print or Write)

15. SIGNATURE OF CLERGYMAN (Print or Write)

16. SIGNATURE OF CHURCH OFFICER (Print or Write)

17. SIGNATURE OF BURIAL OFFICER (Print or Write)

18. SIGNATURE OF INTERMENT OFFICER (Print or Write)

19. SIGNATURE OF FUNERAL HOME (Print or Write)

20. SIGNATURE OF CEMETERY (Print or Write)

21. SIGNATURE OF BURIAL SOCIETY (Print or Write)

22. SIGNATURE OF OTHER (Print or Write)

23. SIGNATURE OF OTHER (Print or Write)

24. SIGNATURE OF OTHER (Print or Write)

25. SIGNATURE OF OTHER (Print or Write)

26. SIGNATURE OF OTHER (Print or Write)

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29. SIGNATURE OF OTHER (Print or Write)

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41. SIGNATURE OF OTHER (Print or Write)

42. SIGNATURE OF OTHER (Print or Write)

43. SIGNATURE OF OTHER (Print or Write)

44. SIGNATURE OF OTHER (Print or Write)

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. PLACE OF DEATH (Print or Write)

9. TIME OF DEATH (Print or Write)

10. SIGNATURE OF PHYSICIAN (Print or Write)

11. SIGNATURE OF REGISTRAR (Print or Write)

12. SIGNATURE OF WITNESSES (Print or Write)

13. SIGNATURE OF DECEASED (Print or Write)

14. SIGNATURE OF NEXT OF KIN (Print or Write)

15. SIGNATURE OF CLERGYMAN (Print or Write)

16. SIGNATURE OF CHURCH OFFICER (Print or Write)

17. SIGNATURE OF BURIAL OFFICER (Print or Write)

18. SIGNATURE OF INTERMENT OFFICER (Print or Write)

19. SIGNATURE OF FUNERAL HOME (Print or Write)

20. SIGNATURE OF CEMETERY (Print or Write)

21. SIGNATURE OF BURIAL SOCIETY (Print or Write)

22. SIGNATURE OF OTHER (Print or Write)

23. SIGNATURE OF OTHER (Print or Write)

24. SIGNATURE OF OTHER (Print or Write)

25. SIGNATURE OF OTHER (Print or Write)

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41. SIGNATURE OF OTHER (Print or Write)

42. SIGNATURE OF OTHER (Print or Write)

43. SIGNATURE OF OTHER (Print or Write)

44. SIGNATURE OF OTHER (Print or Write)

BUREAU V. 2

SEP 4 1956

RECEIVED

REGISTERED, R.D. HARRIS, JR.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **08356-5**

8371

| | | | | | | | | |
|---|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u> | | | c. LENGTH OF STAY IN 1b <u>4 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u> | | | | d. STREET ADDRESS <u>RFD #1</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Eugene Sterling Rumsey</u> | | | | 4. DATE OF DEATH Month Day Year <u>August 22 1956</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 7 1937</u> | | |
| 9. AGE (In years last birthday) <u>19</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer on farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md Harford Co</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S</u> | | |
| 13. FATHER'S NAME <u>Willard Rumsey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Doris Annie Miles</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-32-8173</u> | | 17. INFORMANT <u>Munkhara Rumsey</u> Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>Rheumatic Carditis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bel-air, Md. Harford Co</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>August 18, 1956</u> to <u>August 22, 1956</u> , that I last saw the deceased alive on <u>August 22, 1956</u> , and that death occurred at <u>2:30 P. M.</u> from the causes and on the date stated above. | | | | | | | | |
| ACTUAL SIGNATURE <u>George T. Stansbury</u> | | | | ADDRESS (Street, city or town, state) <u>569 Revolution St., Harford Grace, Md.</u> | | | | |
| PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> | | | | DATE SIGNED <u>8/22/56</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>25, 1956</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>AS Bailey</u> | | | | ADDRESS <u>Harlington Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>Aug. 25, 1956</u> | | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1956 42 511.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08357

8382

CERTIFICATE OF DEATH

Reg. Dist. No.

191

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen #2</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Rural #2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Parsius Run</u> | | d. STREET ADDRESS <u>Parsius Run</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Samantha</u> Middle <u>A.</u> Last <u>Simmons</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>22</u> Year <u>1956</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 30 - 1882</u> |
| 9. AGE (In years, lost birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Lyons</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Hughes</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>James M. Simmons</u> Address <u>Aberdeen #2, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>—</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 54</u> , to <u>Aug 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 21</u> , 19 <u>56</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Dudley Phillip</u> | | DATE SIGNED <u>8/23/56</u> | |
| PHYSICIAN'S NAME (Type) | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug 24 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Wt Zion Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bel Air R.T. Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrington</u> | | ADDRESS <u>Aberdeen Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>Aug 24 - 56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Mellie G. Perry</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|------------------------------|--|--------------------------|--|--------------------------|--|--------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|-------------------------------|--|-----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Date of death | | 6. Place of death | | 7. Cause of death | | 8. Manner of death | | 9. Signature of physician | | 10. Signature of registrar | |
| John Doe | | Male | | 45 | | 1/1/1910 | | 1/15/1956 | | Boston, Mass. | | Heart disease | | Natural | | [Signature] | | [Signature] | |
| 11. Occupation | | 12. Education | | 13. Marital status | | 14. Usual place of abode | | 15. Usual place of death | | 16. Usual place of burial | | 17. Name of funeral home | | 18. Name of undertaker | | 19. Name of cemetery | | 20. Name of church | |
| Teacher | | High School | | Married | | Home | | Home | | Home | | Doe & Sons | | Doe & Sons | | Doe & Sons | | Doe & Sons | |
| 21. Name of informant | | 22. Relationship to deceased | | 23. Address of informant | | 24. Telephone number | | 25. Date of completion | | 26. Signature of informant | | 27. Signature of registrar | | 28. Signature of physician | | 29. Signature of funeral home | | 30. Signature of undertaker | |
| Jane Doe | | Wife | | 123 Main St. | | 123-4567 | | 1/15/1956 | | [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |

BUREAU V. S.

1956 7 15

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8383

CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u> | | c. LENGTH OF STAY IN TB <u>60 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>Water Vale Rd</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Henry Sullivan</u> | | 4. DATE OF DEATH Month Day Year <u>Aug 27 1956</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 14 / 1873</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rail Road Conductor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Michael Sullivan</u> | | 14. MOTHER'S MAIDEN NAME <u>Frances Hill</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | |
| 17. INFORMANT <u>Mrs Laura H. Haid</u> Address <u>Fallston MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE: 332X DUE TO <u>Cerebral thrombosis, recurrent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arterio sclerosis</u> DUE TO (b) <u>90117</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured rt femur, with subcutaneous abscess</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>??</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb. 18</u> , 19 <u>56</u> , to <u>Aug. 27</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Aug. 27</u> , 19 <u>56</u> , and that death occurred at <u>1 P. M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Charles Frederick</u> | | DATE SIGNED <u>Aug 27 1956</u> | |
| PHYSICIAN'S NAME (Type) <u>Charles Frederick</u> | | ADDRESS (Street, city or town, state) <u>126 S Main, Bal An, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Aug 30 / 56</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Lionsbrun Balto Co MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster Bel An MD</u> | | ADDRESS <u>MD</u> | |
| 24a. REC'D BY REGISTRAR <u>8-28-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Micella Lowwood</u> | |

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CERTIFICATE OF DEATH

Reg. Dist. No.

181

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Wash. b. COUNTY Harford King | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Grace Seattle 84 X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, APG, Md. | | d. STREET ADDRESS 634 Ontario 15107 24th S W | |
| 3. NAME OF DECEASED (Type or print) Patricia Elena VON GORTLER | | 4. DATE OF DEATH August 27 1956 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 27, 1956 |
| 9. AGE (In years last birthday) yrs. | | IF UNDER 1 YEAR | IF UNDER 24 HRS. |
| | | Months | Days |
| | | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME Frederick Carl Von Gortler III | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 14. MOTHER'S MAIDEN NAME Patricia Elena Fitzgerald | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Father | | Address (same as 2) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia, shock 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Prematurity, precipitate delivery DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs 40 min |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from August 27 , 19 56 , to August 27 , 19 56 , that I last saw the deceased alive on August 27 , 19 56 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Hreidar Agustsson | | ADDRESS (Street, city or town, state) 2157-1 US Army Hospital Aberdeen Pro Ground. | |
| PHYSICIAN'S NAME (Type) HREIDAR AGUSTSSON, Major, MC | | DATE SIGNED Aug 27, 1956 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Aug 30-1956 | 22c. NAME OF CEMETERY OR CREMATORY Post Cemetery APG | 22d. LOCATION (City, town, or county) (State) Aberdeen Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John G. Harving Aberdeen Md. | | 24a. REC'D BY REGISTRAR DATE Aug 29-56 | 24b. REGISTRAR'S SIGNATURE Hellie R. Perry |

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 185

| | | | | | | | |
|---|----------------------------------|--|--|--|---|--|--------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Md</u> | | COUNTY <u>Cecil</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> | | LENGTH OF STAY (In this place) <u>1 hr. 20 Min</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> | | TOWN <u>Port Deposit</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>RD# 1</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Helen Elizabeth Walker</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 29 1956</u> | | | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Oct. 15, 1904</u> | 9. AGE last birthday <u>51</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Clifford Smeltzer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mable Scott</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT & ADDRESS <u>McWittie Walker, Port Deposit, Md</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 416X IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumatic Cardio Vascular Disease</u> | | | | | | <u>20 yrs</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21i. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept 27</u> , 19 <u>54</u> , to <u>Aug 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 27</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.</u> M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>[Signature]</u> | | | | ADDRESS (Street, city, town, state) <u>Port Deposit, Md</u> | | DATE SIGNED <u>8-29-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Sept. 1, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>Hopewell</u> | | LOCATION (city, town, or county) (State) <u>Port Deposit, Md. Rural</u> | |
| 24. REC'D BY REGISTRAR <u>Aug. 30-56</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> | | ADDRESS <u>Perryville, Md.</u> | |

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8385

CERTIFICATE OF DEATH

08361

Reg. Dist. No. 102

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|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shawsville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shawsville</u> | | | |
| c. LENGTH OF STAY IN 1b <u>42 yrs</u> | | | | d. STREET ADDRESS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Cora</u> First <u>Garrett</u> Middle <u>Wright</u> Last | | | | 4. DATE OF DEATH <u>Aug</u> Month <u>29</u> Day <u>1956</u> Year | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Oct 31-1880</u> | |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Shawsville Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James Garrett</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie Strawbridge</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Leslie F Wright</u> Address <u>White Hall, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia and</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Degenerative</u> <u>Advanced Arterio-Sclerosis</u> DUE TO (c) <u>Diabetes - II</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 1/2 yrs</u> <u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>Aug 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 29</u> , 19 <u>56</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>William O. Fulton</u> M.D. | | | | DATE SIGNED <u>Aug 30</u> | | | |
| PHYSICIAN'S NAME (Type) <u>William O. Fulton, MD</u> | | | | <u>Stewartstown, Pa.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept 1-56</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Dry Branch</u> | | 22d. LOCATION (City, town, or county) (State) <u>Dry Branch - White Hall Pa</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skrup</u> ADDRESS <u>Janet Road</u> | | | | DATE <u>9-3-56</u> | | 24b. REGISTRAR'S SIGNATURE <u>Priscilla Souworn</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

